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Helen Bamber Foundation
working with survivors of human cruelty

The Helen Bamber Foundation's Evidence to the Department of Health Formal Review of 'The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017'

The Helen Bamber Foundation (HBF) is a UK charity that provides expert care and support for refugees and asylum seekers who have suffered extreme physical, sexual and psychological violence, abuse and exploitation. The individuals we work with have been subjected to atrocities including state-sponsored torture, religious / political persecution, human trafficking, forced labour, sexual exploitation, gender-based and 'honor-based' violence. Most of our clients have been repeatedly and systematically victimised, sometimes for years. As a result of their experiences, our clients have multiple and complex needs including: acute psychological health conditions, severe physical injuries and medical conditions, extreme vulnerability to further exploitation, risk of further persecution, homelessness, destitution and intense loneliness.

HBF offers survivors access to an individually tailored programme of specialist psychological care and physical rehabilitation activities alongside an advisory medical clinic, expert medico-legal assessment and documentation, welfare and housing support and a creative arts and employability skills programme. Our work helps survivors to gain stability, to address and overcome their trauma and to integrate into the community, resulting in sustained recovery.

In our service, we have become increasingly concerned regarding the impact on our most vulnerable clients of 'The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017', particularly the extension of charging into community services and the requirement for relevant bodies to charge upfront for treatment that is not urgent or immediately necessary,. We believe the following case studies provide evidence of how these regulations are impacting negatively on the vulnerable individuals we work with by deterring and/or preventing them from accessing services that they need and are (more often than not) fully entitled to. Although we understand that the scope of the review is to examine the impact of regulations introduced on 23rd October 2017, we are aware that several trusts were involved in 'piloting' these regulations before this date. The evidence below spans a period of time before this date, but is nonetheless relevant in informing our forecast of the likely future impact on vulnerable groups such as our clients.

1. Extending Charging into Community Services

Any NHS-funded organisation that provides community based services is now legally required to check the eligibility of patients, and, in some circumstances, charge them for their care. Relevant community services regularly accessed by our clients include: community midwifery, community mental health services, drug and alcohol treatment services, and routine screening for non-infectious diseases.

As a result of their prior experiences, the vast majority of HBF clients have significant and complex mental health problems requiring the attention of services provided by Community Mental Health Teams (CMHTs).

Despite often belonging to exempt categories as victims of trafficking, torture, sexual violence, refugees, and asylum seekers the lack of clarity and misinformation about who is eligible for free care has had a deterrent effect and made many vulnerable individuals reluctant to present to services. Our clients are often unable to provide the documents they are requested to bring in appointment letters or their legal situations are complex and administrative staff are unable to determine their eligibility to care due to not receiving sufficient training or being suitably knowledge about immigration law.

CMHTs have also required prolonged discussion and evidencing from our staff before relenting to give treatment. This is not what non-statutory organisations with heavy workloads supporting vulnerable individuals should be having to spend their time doing.

We note that the regulations in question were only recently introduced, and believe this review to be premature. We anticipate that the number of incidents we see similar to this is only going to increase in number as more Trusts begin to implement the regulations more rigorously. We do not think this review will fully capture the future impact of these regulations.

Case Study

S* is a lady in her 50s from Bangladesh. She fled her home country after suffering considerable sexual, physical, and psychological at the hands of her estranged husband and his family. As a result of these experiences she is traumatised and highly vulnerable. She has been diagnosed with Post-Traumatic Stress Disorder (PTSD) and often reports feeling suicidal.

S was an asylum seeker in receipt of Asylum Support. In June 2017 her mental health deteriorated causing significant concern to her support team at HBF. She was seen at HBF floridly psychotic, profoundly depressed and with worsening symptoms of PTSD. In Spring 2017 she was cutting herself and attempted suicide by overdose

She was referred to her local CMHT at a time when she presented a significant risk of harm to herself, but was confused and anxious about her entitlement following receipt of a letter stating she needed to bring a valid passport and a current Council tax bill AND a recent Utility bill or bank statement. She was particularly concerned by the sentence in the appointment letter she received from the CMHT which suggested that her care would be delayed were she to not bring these documents.

As a vulnerable asylum seeker living precariously, she was not in possession of either of documents the CMHT was requesting. Despite this, she was fully entitled to the care provided by the CMHT and badly needed it.

She had previously struggled to engage with statutory mental health services and this represented her first engagement with the service. She discussed her reluctance to present to the service with staff at HBF but after two members of staff wrote to the CMHT as well as a member of staff from another organisation she attended the appointment.

- Do you have any evidence of how extension of charging into relevant services provided in the community, or to non-NHS providers of relevant services, has had a particular impact on any other vulnerable group?

In the light of the evidence provided in the case study above and our experience with several other very vulnerable clients, we have reason to believe that the extension of charging into community services has had particular impact on vulnerable groups. If our staff had not been able to advise this woman, she would have disengaged from community services at a time where she was floridly psychoti, and a risk to herself and others.

- Do you have any evidence of how extension of charging into relevant services provided in the community, or to non-NHS providers of relevant services, may have deterred individuals from seeking treatment?

We believe the obligation to check patient eligibility at the point of access has a deterrent effect on some of our clients, many of whom are vulnerable asylum seekers and refugees and thus entitled to this care. Our clients are often unable to provide the documentation requested due to their often precarious situations; they are also often homeless, destitute, and live with mental health conditions. Many also misunderstand the implications of being requested to bring these items to appointments, as they have often had protracted experiences with the Home Office in securing their immigration statuses. They may incorrectly believe that they are not entitled or will not be seen if they cannot bring documentation.

2. The requirement for all relevant bodies to charge upfront for treatment that is not immediately necessary or urgent

It is difficult for vulnerable individuals to demonstrate upfront their entitlement to care. There is also confusion over what constitutes ‘immediately necessary’ and ‘urgent’ care, with one client of ours being refused what we deem to be lifesaving care. These are additional barriers to healthcare for vulnerable groups, particularly when their first language is not English.
Outstanding bills are also being used by hospitals as grounds to withhold further treatment, where the necessity of the new course of treatment is not being assessed.
An increased focus on identifying chargeable patients it also distracting staff from their duties to identify vulnerable adults.

Case Study

N* is a lady in her early thirties who was trafficked to the UK. She collapsed in May 2017 and was taken to hospital and stabilised was found to have suffered an Out of Hospital Ventricular Fibrillation Arrest secondary to a myocardial infarction, a medical emergency which carries a survival rate of 8%. She was told to leave the hospital after only several days as she was advised that due to her immigration status she would have to pay for further treatment, which she could not afford. After leaving the hospital she immediately went to claim asylum but in whilst attending the Asylum Screening Unit she collapsed again and was taken to a different hospital. She received no interventions and was again discharged after being advised that due to her immigration stratus she would not be able to afford care.

At 3am the day she was discharged from the second hospital she had another heart attack and was taken back to the same hospital and was prepared by staff to undergo an operation. As she was waiting to go to theatre the doctor came to tell her that she would not have the operation and she was discharged.

Two days later she again experienced an episode of severe back pain radiating to the left arm and was taken to a third hospital from where she was sent on to a tertiary centre where she received further investigations and medical care, although she was informed that the hospital was restricted in the care they could provide due to her immigration status.

Investigations have shown that her heart is now functioning at only 30% of the normal level, but the tertiary centre have told her they are not clear whether they can provide her with the operation to be fitted with a device that could save her life due to their confusion over her immigration status and her outstanding medical bills. This despite her now having claimed asylum and being fully entitled to this life-saving care as an asylum seeker and a victim of trafficking. She is incredibly anxious, and worried that she may die before she can have the operation she needs.

This case demonstrates a lack of clarity over the implementation of the regulations. There is reason to believe that the clinical decisions that were informed in part by questions over this woman's immigration status led to significant further harm. For this reason we are believe that further guidance should be provided on what constitutes 'immediately necessary' or 'urgent' care. This case study also demonstrates that a focus in immigration status may lead to the neglect of a duty of care to vulnerable adults. No member of staff took the time to identify this woman, who from her history and background should have raised suspicions that she was a victim of human trafficking and should therefore (subject to her consent) have been referred to a 'competent authority'. There was also confusion (despite clear guidance on the eligibility of asylum seekers to care) dover what she was entitled to once she had claimed asylum. This her entitlement to care was once she had claimed asylum.

- Do you have any evidence of how the requirement to charge upfront for treatment that is not immediately necessary or urgent, has had a particular impact on any other vulnerable group?

This case demonstrates that confusion and a lack of clarity is impacting negatively on victims of trafficking and asylum seekers, who are receiving bills and being misinformed that they are to eligible to receive treatment when they in fact are.

3. Recording when a patient is an overseas visitor

- Do you have any evidence pf how the requirement to record a patient's overseas visitor status has had a particular impact on any other vulnerable group?

There is reason to believe that the delays in records being updated are impacting vulnerable groups. For example, the woman in the second case study is still recorded as ineligible on hospital records despite having claimed asylum and as such her care is being impacted. We believe that similar delays may affect refused asylum seekers who on appeal are granted refugee status.

4. Other concerns

We also note that this review is perhaps premature, as these changes seem not to have been 'bedded in' to many services yet. This suggests that the potential harm caused by these regulations may only increase.

* Not for publication without the express written permission of the Helen Bamber Foundation. This case study has been anonymised.